SPSO decision report

Case: **201508628, Lanarkshire NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his mother (Mrs A) during her admissions to Monklands Hospital and Coathill Hospital. Mrs A was suffering from dementia when she was admitted with a urinary tract infection. Mrs A deteriorated whilst in hospital and died just over two months after admission. Mr C said he had visited his mother every day and repeatedly asked to speak with the consultant responsible for her care. He was not given an appointment for over two months. Mr C said Mrs A's medical notes also showed that his mother had been designated as not fit for resuscitation on the day of her admission to Monklands Hospital. Mr C had not been informed of this for two months despite having welfare power of attorney for Mrs A, who had only a very limited ability to communicate. Mr C said Mrs A's ring had gone missing and that staff had failed to look for it. Mr C added that the board's complaints process had taken too long and been inadequate. Mr C also complained that an advocate was inappropriately involved by medical staff against Mrs A's wishes and that staff refused to explain why. Mr C also complained Mrs A had been forced to attend a Christmas party, which her family did not want her to do.

We took independent medical advice on the care and treatment provided. The advice said that Mrs A's designation as not for resuscitation was a medical decision and did not need the family's approval. It should, however, have been discussed with them as a matter of good practice. The advice noted the paperwork for the decision was not properly completed and this had not been reviewed at any point during Mrs A's admission. The advice concluded that the standard of communication with Mr C had fallen below a reasonable standard and that he should have had the opportunity to discuss Mrs A's care much earlier in her admission. The reason for involving an advocacy service should have been recorded and it was inappropriate for board staff to imply that it was required due to difficulties in communicating with Mr C without evidence to support this. The advice also said whilst taking Mrs A to a Christmas party on the ward was done with kind intentions, it should have been discussed with Mr C and the failure to do this had caused the family great distress.

We found communication with Mr C fell below a reasonable standard. Records for the decision to designate Mrs A as not for resuscitation and referral to an advocacy service were not completed properly. These decisions should have been discussed with Mr C, but were not. We also found that staff failed to communicate appropriately about the missing ring and that the evidence did not show any significant effort being made to locate it, despite promises being made to the family. We upheld the complaint.

Recommendations

We recommended that the board:

- provide evidence that the actions identified in response to this complaint have been implemented;
- provide evidence of how they are monitoring the effectiveness of their new communication measures;
- review the process for discussing the decision to designate a patient as not for resuscitation with the patient or their carers, in light of the failure by medical staff to follow existing procedures in this case;
- remind ward staff of the need to ensure valuables are logged on admission, especially if the patient has a

limited or impaired ability to communicate;

- provide evidence they have reviewed their procedures when items go missing so that staff are clear on the procedure to follow and information is shared appropriately between shifts; and
- review the process for referring patients to advocates to ensure that reasons for referral are clearly documented and discussed with the patient or their carers.